SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
(●) Worker's Compensation Claim ( ) Incident Only Report	Ongoing Supervisor's Date of Knowledge: 2/27/19	N/a ( ) a.m. ( ) p.m. Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Emp#
JMS		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time:	End Time:
F/T	☐ ☐☐☐☐☐☐☐	( ) a.m. ( ) p.m.	( ) a.m. ( ) p.m.

INCIDENT INFORMATION

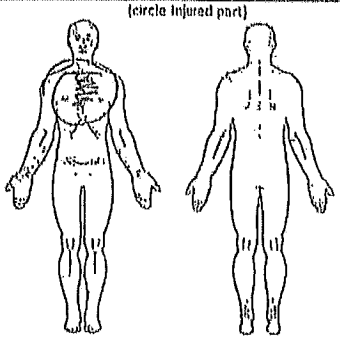
Injured Body Part: Chronic lung issues

Type of Injury: Asthma or COPD

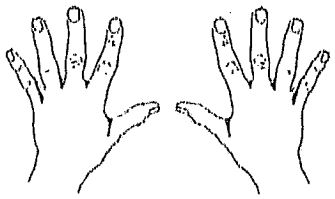
Action Causing Injury: Environmental

Contributing Object/Equipment: Poor air quality

(circle injured part)

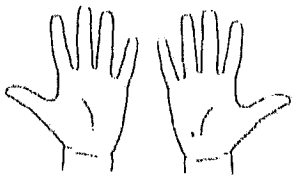


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

I have been having chronic breathing problems worsening in the last two weeks. My physician is treating me for environmentally induced asthma or COPD

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes (●) No ( ) Assumed - my file removed	PSFA Building	

Name & contact information of Witness: None ☐	Was another person responsible?	Were other employees injured?
from outside my office for 2 weeks	Yes ( ) No (●)	Yes ( ) No ( )
	Name & contact information of responsible party?	Were Campus Police notified? Yes ( ) No (●)

Did the employee miss any work related to the injury? No (●) Yes ( ) If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required

( ) None ( ) Emergency Room
( ) First Aid ( ) Hospitalization
(●) Medical Care: Pulmonology/inhalers

Medical Facility

(●) Sharp Rees-Stealy
( ) Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☐ Other: Relocated

Completed By (Print Name) Signature Date 2/07/19

2/26/19 Rev. 1/23/13

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ◉ Incident Only Report

Date of Injury: 2/4/19
Time of Injury: continuous throughout p.m. today
Supervisor's Date of Knowledge: 2/4/19
Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
Public Affairs		

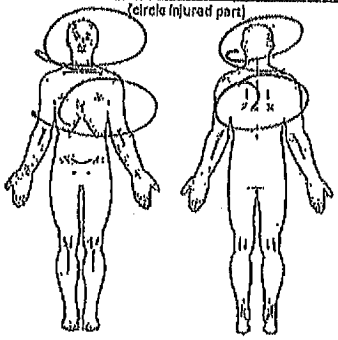
Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week: 40+
Days Worked: M-F ☒ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐
Start time: 7:00 ○ a.m. ○ p.m.
End Time: 4:00 ○ a.m. ◉ p.m.

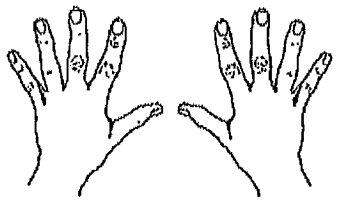
INCIDENT INFORMATION

Injured Body Part: head / lungs
Type of Injury: Illness
Action Causing Injury: Fumes from roof repair
Contributing Object/Equipment:

(circle injured part)

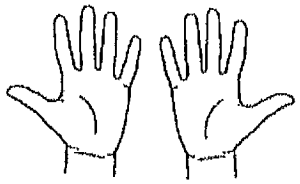


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

headaches & coughing when at workplace.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA Building SDSU	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ○ No ◉	Yes ◉ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ?

Did the employee miss any work related to the injury? No ◉ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required
- ◉ None
- ○ First Aid
- ○ Medical Care
- ○ Emergency Room
- ○ Hospitalization

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:
Physician/Facility Name:
Address:
Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: Relocated to another build.

Completed By (Print Name)

Signature

Date: 3/21/19

3/21/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	Jan. 31, 2019 Supervisor's Date of Knowledge: Jan. 31, 2019	10:00 ◉ a.m. ○ p.m. Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
School of Public Affairs		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40	☑	☐	☐	☐	☐	☐	☐	☐	08:00 ◉ a.m. ○ p.m.	7:00 ○ a.m. ◉ p.m.

INCIDENT INFORMATION

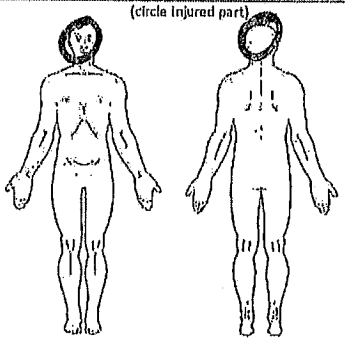
Injured Body Part: Other: Head

Type of Injury: Other: Pain

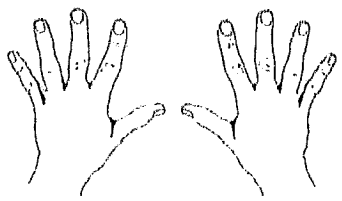
Action Causing Injury: Dust/Gas/Fumes/Vapors

Contributing Object/Equipment:

(circle injured part)

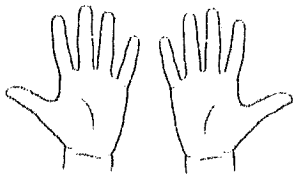


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Headache and vision issues possibly related to construction fumes in PSFA building. Visited nurse practitioner in after a few days of headaches.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
◉ Yes ○ No	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
☐ None	○ Yes ○ No	○ Yes ○ No
	Name & contact information of responsible party?	Were Campus Police notified? ○ Yes ○ No

Did the employee miss any work related to the injury? ○ No ◉ Yes If yes, Date: 2/1/19 Time From: 8:00 a.m. To: 4:30 p.m.

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ○ Emergency Room ○ First Aid ○ Hospitalization ⊗ Medical Care	◉ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: SUMAtripan Succinate 25 MG

Completed By (Print Name)	Signature	Date
		3/20/19

3/20/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as: ○ Worker's Compensation Claim ☒ Incident Only Report	Date of Injury 3-1-2019 2-28-19	Time of Injury 11am approx ☒ a.m. ○ p.m.
	Supervisor's Date of Knowledge 2-28-19	Date DWC-1 Given to Employee 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
Public Affairs		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week	Days Worked	Start time	End Time
40	☒ M-F ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S	○ a.m. ○ p.m.	○ a.m. ○ p.m.

INCIDENT INFORMATION

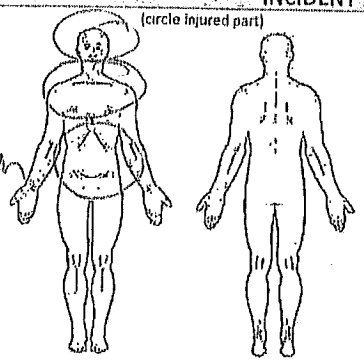
Injured Body Part: head/chest/stomach

Type of Injury: dizziness, vomiting, shortness of breath

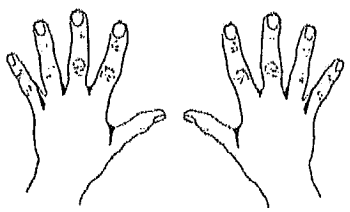
Action Causing Injury: unknown - possible air quality

Contributing Object/Equipment:

(circle injured part)

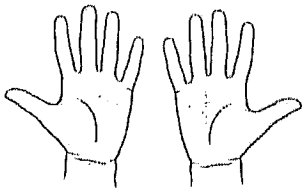


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Sudden onset dizziness and shortness of breath, followed by vomiting, while working in office. Left premises and symptoms resolved within 20 min.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ○ No ☒	Yes ○ No ☒
	Name & contact information of responsible party?	Were Campus Police notified?
		Yes ○ No ☒

Did the employee miss any work related to the injury? No ○ Yes ☒ If yes, Date: 2-28-19 Time From: 12pm To: 4pm

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ○ Emergency Room ○ First Aid ○ Hospitalization ☒ Medical Care	○ Sharp Rees-Stealy ☒ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated to another bldg Sent home

Completed By (Print Name) [illegible] Signature [illegible] 3-7-2019

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as: ○ Worker's Compensation Claim ⊗ Incident Only Report

Date of Injury: 2/28/19

Time of Injury: 10Am-2:30pm ○ a.m. ○ p.m.

Supervisor's Date of Knowledge: 2/28/19

Date Notice Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (ex. Custodian, Student Intern)	Email
HTM		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week: 20+

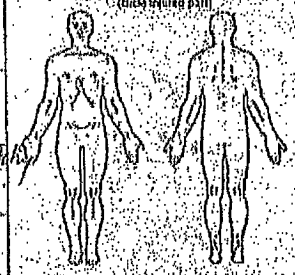
Days Worked: M-F ☐ S ☐ M ☑ T ☑ W ☐ Th ☑ F ☑ S ☐

Start Time: ⊗ a.m. ○ p.m. 10:00

End Time: 3:00 ○ a.m. ⊗ p.m.

INCIDENT INFORMATION

Injured Body Part



(circle injured part)

BACK OF HAND (circle injured part)

Left Right

FRONT OF HAND (circle injured part)

Left Right

Type of injury: Exposure to fumes

Action Causing Injury: Chest, breathing, throat

Contributing Object/Equipment:

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb): Upon arrival, there was a strong chemical smell outside the west entrance of the building but the inside was okay. The fumes became noticeable at our 11:00 meeting and increased throughout the day. I felt ill for several hours after leaving work.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ⊗ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ⊗	Were other employees injured? Yes ⊗ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ⊗

Did the employee miss any work related to the injury? No ⊗ Yes ○ If yes, Date: Time From: To:

Working at home today 3/1

MEDICAL INFORMATION

Medical treatment required:
⊗ None ⊗ Emergency Room
⊗ First Aid ⊗ Hospitalization
⊗ Medical Care

Medical Facility: ○ Sharp Rees-Stealy ○ Other

If other, please complete the following:
Physician/Facility Name:
Address:
Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered
☐ Training Scheduled ☐ Repairs Ordered ☑ Other: Relocated / sent home

Completed by (Print Name): Signature: Date: 3/19/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

WC as of 3/18/19

3019222223000001

File as:	Date of Injury	Time of Injury
⊘ Worker's Compensation Claim ⊙ Incident Only Report	2/26/19	2:30 - 4:00 pm ○ a.m. ⊘ p.m.
	Supervisor's Date of Knowledge: 2/26/19	Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time:	End Time:
8	☑ ☐ ☐ ☐ ☐ ☐ ☐ ☐	8 ⊙ a.m. ○ p.m.	4:30 ○ a.m. ⊙ p.m.

INCIDENT INFORMATION

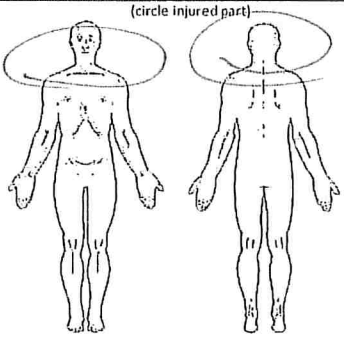
Injured Body Part

Type of ~~Injury~~ Symptoms: nose bleed, headaches,

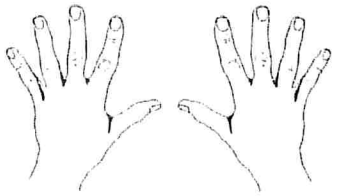
Action Causing Injury

Contributing Object/Equipment

(circle injured part)

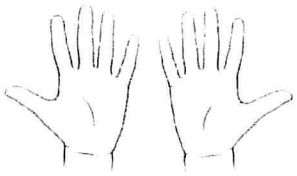


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Work being done on the roof of PSFA which caused the fumes to enter into the building. Fumes being inhaled by faculty, staff & students throughout the building

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ⊙ No ○	PSFA Building	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
Multiple office staff have experience some or all of the same symptoms ☐ None	Yes ○ No ○	Yes ⊙ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ⊙

Did the employee miss any work related to the injury? No ○ Yes ⊙ If yes, Date: 2/25 Time From: 3:30 To: 4:30

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
⊙ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☑ Repairs Ordered ☑ Other: Multiple attempts to work with facilities project mgmt to correct issues

Completed By (Print Name)

2/27/19
Date

WC as of 3/18/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ☒ Incident Only Report	Tues. Feb 26 Supervisor's Date of Knowledge Tues Feb. 26	Respiratory ○ a.m. ☒ p.m. Date DWC-1 Given to Employee 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
30	☒	☐	☐	☐	☐	☐	☐	☐	8 ☒ a.m. ○ p.m.	2:30 ○ a.m. ☒ p.m.

INCIDENT INFORMATION

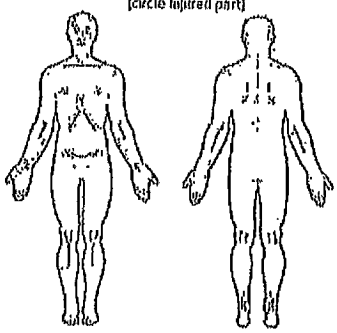
Injured Body Part: lungs/nose sinus

Type of Injury: Respiratory

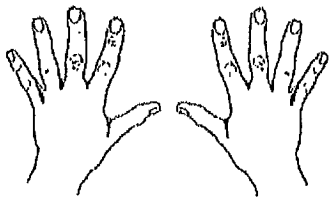
Action Causing Injury: building odor

Contributing Object/Equipment:

[circle injured part]

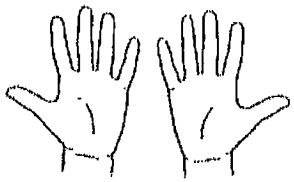


BACK OF HAND [circle injured part]



Left Right

FRONT OF HAND [circle injured part]



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

The building has had a strong odor for a couple of weeks, Yesterday it became very strong & I experienced asthmatic symptoms, ~~and felt~~ that lingered when I left the bldg

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ○	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◆ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Sent home relocated on March 4

Completed By (Print Name) Sig 2/27/19 Date

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ☒ Incident Only Report

Date of Injury: Jan 30-31, Feb 17, Feb 28, 2019

Time of Injury: ○ a.m. ○ p.m.

Supervisor's Date of Knowledge: Jan. 30, 2019

Date DWC1 given to employee:

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
Public Affairs / PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week	Days Worked: M-F S M T W Th F S	Start time:	End Time:
50	☒ ☐ ☐ ☐ ☐ ☐ ☐ ☐	10 ☒ a.m. ○ p.m.	7 ○ a.m. ☒ p.m.

INCIDENT INFORMATION

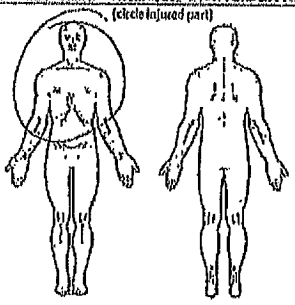
Injured Body Part

Type of Injury: Nausea, dizziness, headaches

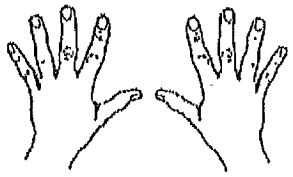
Action Causing Injury: Fumes

Contributing Object/Equipment: Fumes

(circle injured part)



BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)

Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Fumes related to roof repairs have caused nausea, dizziness, & headaches

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☐	Yes ○ No ○ Unknown	Yes ☒ No ○
	Name & contact information of responsible party? Unknown	Were Campus Police notified? Yes ○ No ☒

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required
- ☒ None
- ○ Emergency Room
- ○ First Aid
- ○ Hospitalization
- ○ Medical Care

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:
Physician/Facility Name:
Address:
Phone:

CORRECTIVE ACTION

Supervisor's investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: Relocated on 3/11/19

Completed By (Print Name)

Signature

Date: 3/7/19

3/7/19 Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

(the last month)

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	2/20/19 - 2/27/19	all day ○ a.m. ○ p.m.
	Supervisor's Date of Knowledge: the last month	Date Work Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F ☒ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐	Start Time:	End Time:
40		8:00 ◉ a.m. ○ p.m.	2:30 ○ a.m. ◉ p.m.

INCIDENT INFORMATION

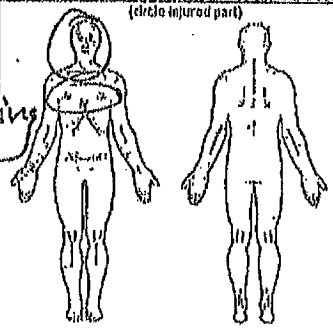
Injured Body Part: headaches nose burning

Type of Injury: trouble breathing

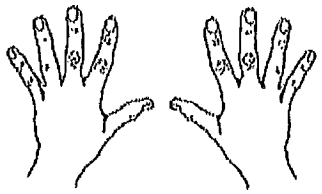
Action Causing Injury: FUMES in Building

Contributing Object/Equipment: Roof repairs causing diff-

(circle injured part)

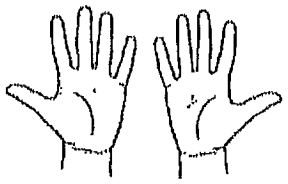


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

passing - Burning eyes, nose, headaches,

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ○	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Sent home Relocated on 3/4/19

Completed By (Print Name) Signature 2/27/19 Date

Rev. 4/23/14

3/19/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	Ongoing Since December	○ a.m. ○ p.m.
	Supervisor's Date of Knowledge: December	Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
HTM		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start Time:	End Time:
40	☑	☐	☐	☐	☐	☐	☐	☐	8:30 ○ a.m. ○ p.m.	5:00 ○ a.m. ◉ p.m.

INCIDENT INFORMATION

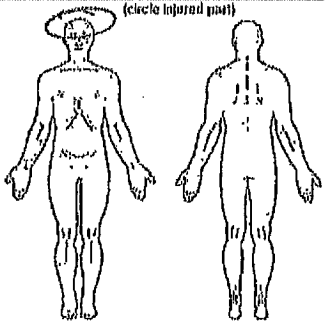
Injured Body Part: Other: Head

Type of Injury: Headaches and light headed

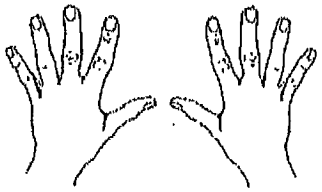
Action Causing Injury: Fumes in building

Contributing Object/Equipment: Roof Work off gasing

(circle injured part)

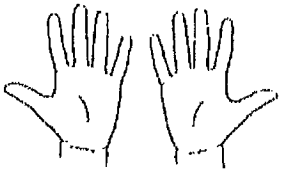


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

There has been ongoing roof work being done which makes our office smell of gasoline fumes. The fumes sometimes become so strong that I begin to feel light headed and eventually get a painful headache.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☐	Yes ◉ No ○	Yes ◉ No ○
	Name & contact information of responsible party? construction	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ○ Yes ◉ If yes, Date: 2/8/19 Time From: To:

have been released early

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Sent home Relocated 3/1/19

Completed By (Print Name) Signature 2/26/19 Date

3/19/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	Jan. 2019 - Present Supervisor's Date of Knowledge: 1/17/2019	Ongoing ○ a.m. ○ p.m. Date DWC-1 Given to Employee: 2/26/2019

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone
	N/A		

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax
			N/A

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40+	☑	☐	☐	☐	☐	☐	☐	☐	◉ a.m. ○ p.m. 8:00	○ a.m. ◉ p.m. 5:00

INCIDENT INFORMATION

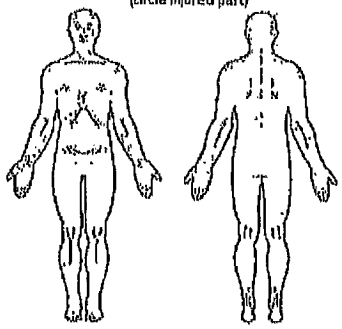
Injured Body Part: Multiple Body Parts

Type of Injury: Other:

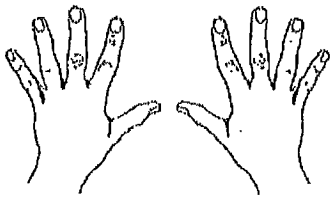
Action Causing Injury: Dust/Gas/Fumes/Vapors

Contributing Object/Equipment: Ongoing construction

(circle injured part)

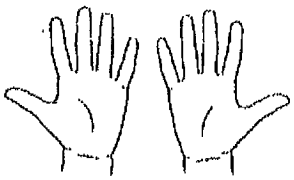


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Inhalation of fumes, vapors, dust, other air particles while existing in the building causing severe headaches and respiratory issues with difficulty breathing.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA building	N/A

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
Other PSFA building occupants None ☐	Yes ○ No ◉ Name & contact information of responsible party? N/A	Yes ◉ No ○ Were Campus Police notified? Yes ○ No ◉

Did the employee miss any work related to the injury? No ◉ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☑ Other: Sent home Relocated 3/4/19

Completed By (Print Name) Signature 2/27/2019 Date

3/19/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ◉ Incident Only Report

Date of Injury: 02/27/19

Time of Injury: 11:40 ◉ a.m. ○ p.m.

Supervisor's Date of Knowledge: 02/27/19

Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week: 40

Days Worked: M-F ☑ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐

Start time: 8:00 ◉ a.m. ○ p.m.

End Time: 4:30 ○ a.m. ◉ p.m.

INCIDENT INFORMATION

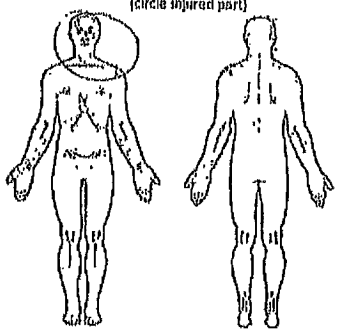
Injured Body Part

Type of Injury: coughing and sinuses

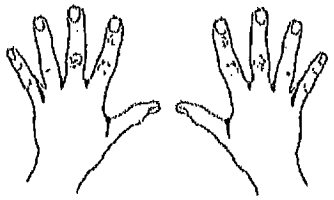
Portion Causing Injury: Environmental fumes

Contributing Object/Equipment

(circle injured part)

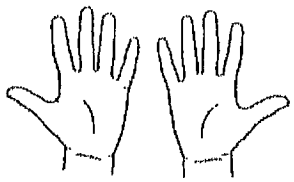


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Starting in January - roof construction on building resulted in "off-gassing" of furnes that were being inhaled by all building occupants

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA Building	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ○	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required:
- ◉ None
- ○ Emergency Room
- ○ First Aid
- ○ Hospitalization
- ○ Medical Care

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☑ Other: Sent home Relocated 3/4/19

Completed By (Print Name)

Signature

Date: 2/27/19

3/19/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ☒ Incident Only Report

Date of Injury: 2/24/19

Time of Injury: 1:45 ○ a.m. ☒ p.m.

Supervisor's Date of Knowledge: 2/26/19

Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First) | Home Phone | Cell Phone | Work Phone

Department: PSFA | Job Title | Email

Supervisor's Name | Supervisor's Work Phone | Supervisor's Email | Supervisor's Fax

Hours Worked Per Week: 40

Days Worked: M-F ☐ S ☐ M ☒ T ☒ W ☒ Th ☒ F ☒ S ☐

Start Time: 8 ☒ a.m. ○ p.m.

End Time: 4:30 ○ a.m. ☒ p.m.

INCIDENT INFORMATION

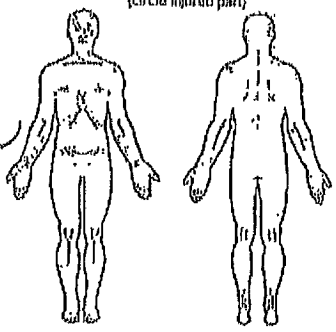
Injured Body Part: lungs

Type of Injury: inhalation

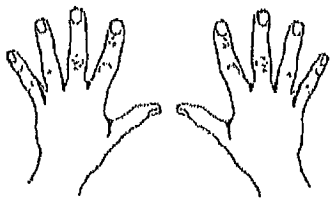
Action Causing Injury: fumes

Contributing Object/Equipment:

(circle injured part)

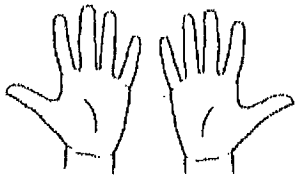


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

after being in building, experienced hard time breathing

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA Building	
Name & contact information of Witness: None ☐	**Was another person responsible?** Yes ○ No ○	**Were other employees injured?** Yes ○ No ○
	Name & contact information of responsible party?	**Were Campus Police notified?** Yes ○ No ☒

Did the employee miss any work related to the injury? No ○ Yes ☒ If yes, Date: 2/24/19 Time From: 2 To: 4:30

MEDICAL INFORMATION

Medical Treatment Required
- ☒ None
- ○ First Aid
- ○ Medical Care
- ○ Emergency Room
- ○ Hospitalization

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: Sent home Relocated on 3/14/19

Completed By (Print Name) | Signature | Date: 2/26/19

2/19/19 Rev. 11/13/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	2/26/2019	○ a.m. ◉ p.m.
	Supervisor's Date of Knowledge 2/26/2019	**Date DWC-1 Given to Employee** 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone
		SAME	

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time:	End Time:
40	☒ ☐ ☐ ☐ ☐ ☐ ☐ ☐	○ a.m. ◉ p.m.	○ a.m. ◉ p.m.

INCIDENT INFORMATION

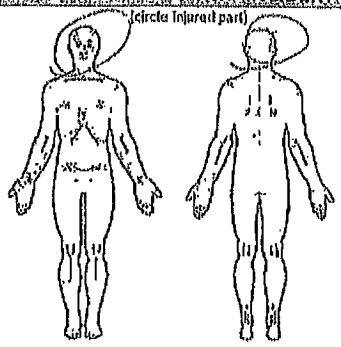
Injured Body Part: EYE BALLS ARE ICKY / COUGH

Type of Injury: FEELING LIGHT HEADED / DIZZY

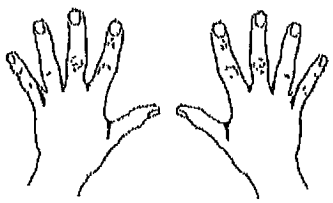
Action Causing Injury: GAS

Contributing Object/Equipment: AIR SMELLS BAD

(circle injured part)

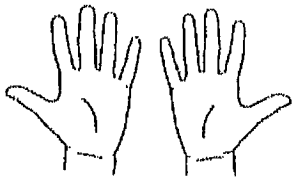


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

EYEBALLS ICKY THROAT IS A BIT SORE, COUGHING AND SOMEWHAT DIZZY

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☐	Yes ○ No ○ NOT SURE	Yes ○ No ○ DO NOT KNOW.
	Name & contact information of responsible party? ??	Were Campus Police notified? Yes ○ No ◉

Did the employee miss any work related to the injury? No ◉ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Moved to AH 3/4/19 Sent home multiple times

Completed By (Print Name) L Signature [redacted] Date 2/26/19

3/19/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ☒ Incident Only Report

Date of Injury: 2-25-19

Time of Injury: 11 ☒ a.m. ○ p.m.

Supervisor's Date of Knowledge: 2/27/19

Date DWC 1 Given to Employee: 2/28/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week: 40

Days Worked: M-F ☒ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐

Start Time: 8 ☒ a.m. ○ p.m.

End Time: 4:30 ○ a.m. ☒ p.m.

INCIDENT INFORMATION

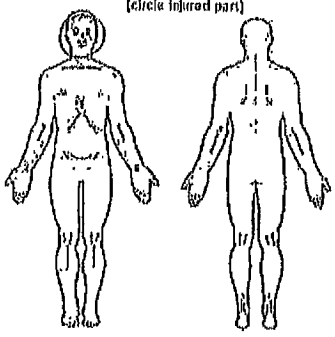
Injured Body Part: Eyes mouth sinus

Type of Injury: burning eyes, metal taste in sinus headache, mouth

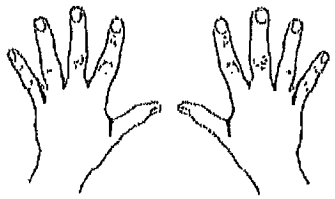
Action Causing Injury: Fumes in building

Contributing Object/Equipment:

(circle injured part)

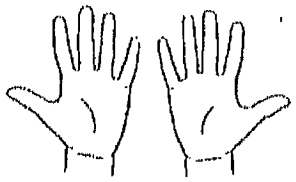


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Fumes in building due to construction

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☐	Yes ○ No ○	Yes ☒ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ☒

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required
- ☒ None
- ○ Emergency Room
- ○ First Aid
- ○ Hospitalization
- ○ Medical Care

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: sent home relocated 3/4/19

Completed By (Print Name)

Signature

Date: 2-28-19

3/19/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the Injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ☒ Incident Only Report

Date of Injury: ONGOING 2/27/19

Time of Injury: ○ a.m. ○ p.m.

Supervisor's Date of Knowledge: 3/4/19

Date DWC-1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
SJMS		@SDSU

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40	☒	☐	☐	☐	☐	☐	☐	☐	○ a.m. ○ p.m. 8:00	4:30 ○ a.m. ○ p.m.

INCIDENT INFORMATION

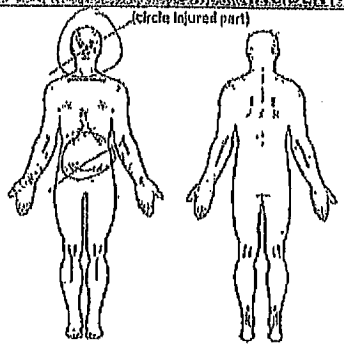
Injured Body Part

Type of Injury

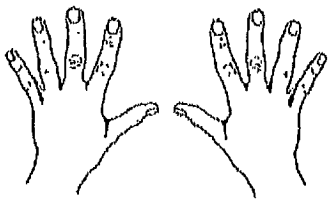
Action Causing Injury: GAS FUMES

Contributing Object/Equipment: CONSTRUCTION

(circle injured part)

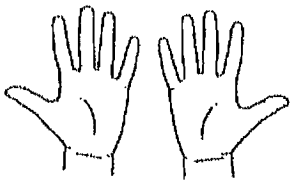


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

FUMES CAUSING MIGRAINES & NAUSEA

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ○ No	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ○ No	Yes ○ No
	Name & contact information of responsible party? PSFA CONSTRUCTION	Were Campus Police notified? Yes ○ No

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required
- ○ None
- ○ Emergency Room
- ○ First Aid
- ○ Hospitalization
- ○ Medical Care

Medical Facility
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: Relocated

Completed By (Print Name)

Signature

Date: 2/27/19

2/26/19

Rev 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ⊗ Incident Only Report

Date of Injury: ongoing

Time of Injury: all day ○ a.m. ○ p.m.

Supervisor's Date of Knowledge: ongoing

Date DWC-1 Given to Employee: 2/20/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
VMS		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week: 40

Days Worked: ☒ M-F ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

Start time: 7:00 ○ a.m. ○ p.m.

End Time: 4:00 PM ○ a.m. ○ p.m.

INCIDENT INFORMATION

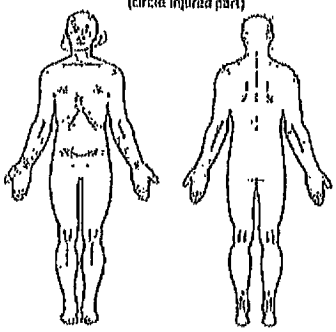
Injured Body Part

Type of Injury

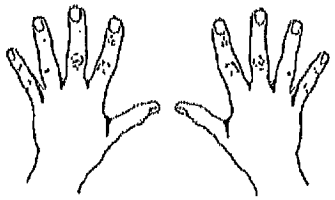
Action Causing Injury: environmental

Contributing Object/Equipment: poor air quality

(circle injured part)

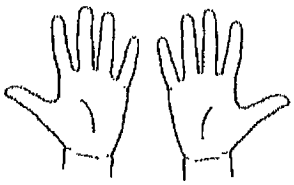


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.) I have been having watery eyes / Red eye / stuffy and bleeding nose / headache

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ⊗ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ○	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ⊗ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required:
- ⊗ None
- ○ First Aid
- ○ Medical Care
- ○ Emergency Room
- ○ Hospitalization

Medical Facility:
- ○ Sharp Rees-Stealy
- ○ Other

If other, please complete the following:
Physician/Facility Name:
Address:
Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☒ Other: Relocated 3/4/19

Completed By (Print Name)

Signature

Date: 2/27/19

Rev. 4/2011

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	2/28/19 Supervisor's Date of Knowledge: 3/8/19	afternoon ○ a.m. ◉ p.m. Date DWC-1 Given to Employee: 3/8/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
JMS	I	

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40 (16 hrs on campu	☑	☐	☑	☑	☑	☑	☑	☐	8-10 ○ a.m. ○ p.m.	2-6:40 ○ a.m. ◉ p.m.

WFT - remote

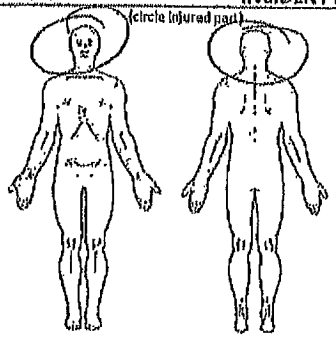
INCIDENT INFORMATION

Injured Body Part: N/A

Type of Injury: Headache

Action Causing Injury: N/A

Contributing Object/Equipment: fumes in PSFA



BACK OF HAND (circle injured part)

Left Right

FRONT OF HAND (circle injured part)

Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

On 2/28/19, after feeling sort of light-headed while working in my office (10am-3pm), I begun experiencing a mild-to-severe, migrane-like headache. I have continued to experience this chronic headache on and off for 12 days. I've since been working remotely due to the fumes.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
◉ Yes ○ No	PSFA	
Name & contact information of Witness: ☑ None	**Was another person responsible?** ○ Yes ◉ No	**Were other employees injured?** ○ Yes ◉ No
	Name & contact information of responsible party?	**Were Campus Police notified?** ○ Yes ◉ No

Did the employee miss any work related to the injury? ◉ No ○ Yes If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ○ Emergency Room ○ First Aid ○ Hospitalization ◉ Medical Care	○ Sharp Rees-Stealy ◉ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☑ Other: Relocated

Completed By (Print Name)	Signature	Date
		3/12/19

3/19/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	February 2019 (ongoing) Supervisor's Date of Knowledge 3-6-19 (formally)	○ a.m. ◉ p.m. Date DWC-1 Given to Employee 3-7-19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone
	N/A		

Department	Job Title (i.e. Custodian, Student Intern)	Email
Public Affairs		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
24 (in office/class)	☐	☐	☑	☑	☑	☑	☐	☐	12:00mw ○ a.m. ◉ p.m.	10:00mw ○ a.m. ◉ p.m.

INCIDENT INFORMATION

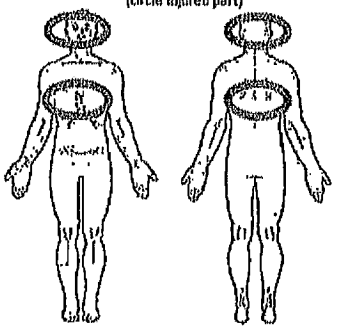
Injured Body Part: Other:

Type of Injury: Other:

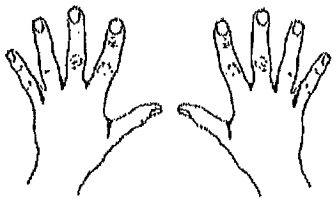
Action Causing Injury: Dust/Gas/Fumes/Vapors

Contributing Object/Equipment:

(circle injured part)

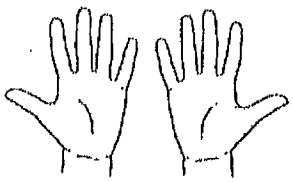


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

There are fumes in our building from construction conducted over the past few of weeks. I have had eye irritation, breathing issues, and headaches since then. Note we have received asbestos notices many times over the years as well.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ◉ No ○	Were other employees injured? Yes ◉ No ○
	Name & contact information of responsible party? Construction company (unknown)	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ◉ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated to new bldg

Completed By (Print Name) Signature 3-11-2019 Date

3/11/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:
- ○ Worker's Compensation Claim
- ◉ Incident Only Report

Date of Injury: on going

Time of Injury: During the day ○ a.m. ○ p.m.

Supervisor's Date of Knowledge: Started 1/14/19

Date Form Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time: ◉ a.m. ○ p.m.	End Time: ○ a.m. ◉ p.m.
8/wk	☑ ☐ ☐ ☐ ☐ ☐ ☐ ☐	8:00	4:30

INCIDENT INFORMATION

Injured Body Part: Head; Nose; Throat; ears

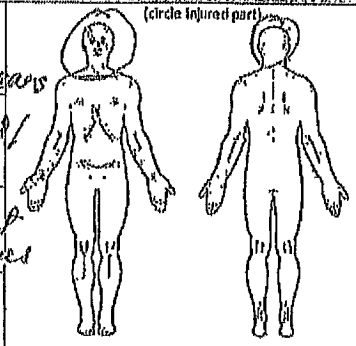
Type of Injury: fumes/gas inhaled/ smell

Action Causing Injury: and sore throat

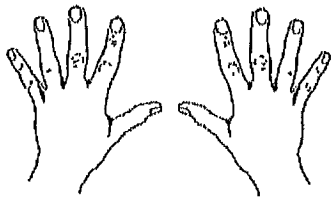
Headache; watery eyes

Contributing Object/Equipment:

(circle injured part)

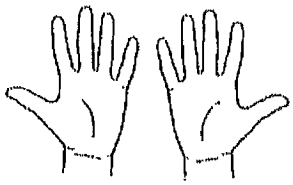


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

gas smell / fumes causes me headache and watery eyes. Later, affects my throat and ears as well

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA Bldg	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ◉	Were other employees injured? Yes ◉ No ○ all staff members affected
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

- ☐ Safety Guidelines Developed
- ☐ Employee Counseled Safety
- ☐ Personal Protective Equipment Ordered
- ☐ Training Scheduled
- ☐ Repairs Ordered
- ☑ Other: Sent home multiple times - Relocated on March 4

Completed By (Print Name) Sign Date 2/27/19

3/19/Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ⊙ Incident Only Report	Jan/Feb 2019 Supervisor's Date of Knowledge: Jan/Feb 2019	○ a.m. ○ p.m. Date DWC-1 Given to Employee: 2/20/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
HTM		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time:	End Time:
30	☑ ☐ ☐ ☐ ☐ ☐ ☐ ☐	⊙ a.m. ○ p.m. 8:00	○ a.m. ⊙ p.m. 2:00

INCIDENT INFORMATION

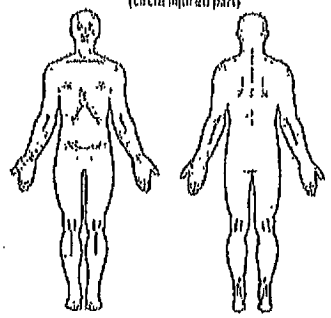
Injured Body Part: eyes, throat, head

Type of Injury: irriation, headaches

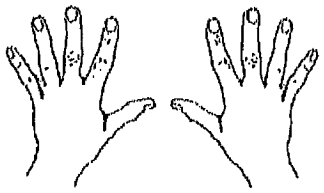
Action Causing Injury: Chemicals in the air

Contributing Object/Equipment:

(circle injured part)



BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)

Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

The PSFA building has been under construction for many months. For the last month there has been toxic smelling air which has given me headaches, itchy and irritated eyes, and sore throats. I have left work early a few days to work at home because it was so bad.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ⊙ No ○	SDSU - PSFA	
Name & contact information of Witness: None ☐	**Was another person responsible?** Yes ○ No ○	**Were other employees injured?** Yes ⊙ No ○
	Name & contact information of responsible party?	**Were Campus Police notified?** Yes ○ No ⊙

Did the employee miss any work related to the injury? No ⊘ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required

○ None ○ Emergency Room
○ First Aid ○ Hospitalization
○ Medical Care

advil, eyedrops, tea

Medical Facility

○ Sharp Rees-Stealy
○ Other

If other, please complete the following:

Physician/Facility Name:

Address:

Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated 3/4/19

Completed By (Print Name) Signature Date: 2/27/19

3/19/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

Isidro Cervantes X41142

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ☒ Incident Only Report	03/04/2019 Supervisor's Date of Knowledge	○ a.m. ○ p.m. Date DWC-1 Given to Employee

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Red ID	Primary Phone
Department	**Job Title** (i.e. Custodian, Student Intern)	**Email**
Supervisor's Name	**Supervisor's Work Phone**	**Supervisor's Email**

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time:	End Time:
	☐ ☐ ☐ ☑ ☑ ☑ ☐ ☐	☒ a.m. ○ p.m. 9:30	○ a.m. ☒ p.m. 7

INCIDENT INFORMATION

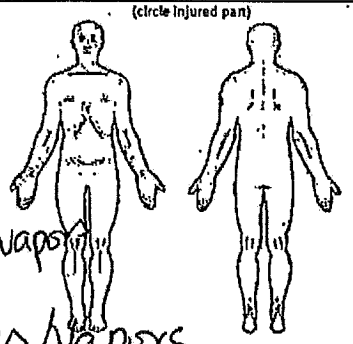
Injured Body Part

Type of Injury: Other

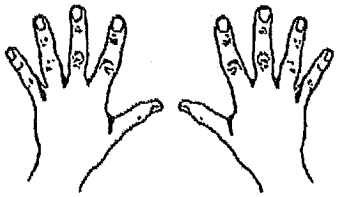
Action Causing Injury: Dust/Gas/Fumes/Vapors

Contributing Object/Equipment: Dust/Gas/Fumes/Vapors

(circle injured part)

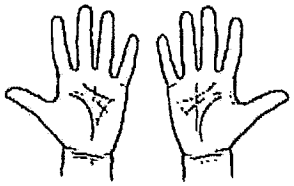


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

When working in PSFA building, I had prolonged menstrual bleeding in March also I coughed more often in March.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ○ No ☒		

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ○ No ☒	Yes ○ No ☒
	Name & contact information of responsible party?	Were Campus Police notified?
		Yes ○ No ○

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
☒ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ☒ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Info Session

Completed By (Print Name) Signature Date 04/29/2019

4/29/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ⊗ Incident Only Report	1-30 to 4-18 2019 Supervisor's Date of Knowledge: 1-30-19	10AM around Thu. ⊗ a.m. ○ p.m. Date DWC-1 Given to Employee: 30

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Red ID	Primary Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
PSFA		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
60	☐	☒	☒	☒	☒	☒	☒	☒	○ a.m. ○ p.m.	○ a.m. ○ p.m.

INCIDENT INFORMATION

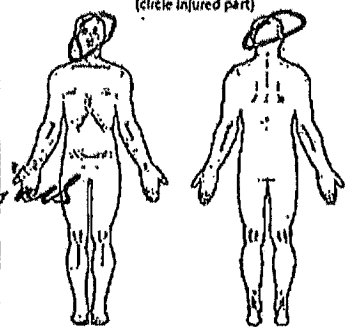
Injured Body Part: face

Type of Injury: rash, shingles, watery eyes, nasal

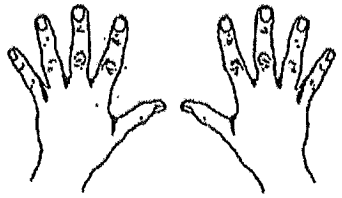
Action Causing Injury: MIXED bldg. fumes

Contributing Object/Equipment: bldg. construction

(circle injured part)

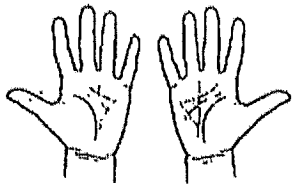


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

fumes contributed to headaches, watery eyes, raw nasal passages, itchy throat. stress caused flare up on face / eye

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ⊗ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ○	Were other employees injured? Yes ⊗ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ⊗ No ○

Did the employee miss any work related to the injury? No ○ Yes ⊗ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ○ Emergency Room ○ First Aid ○ Hospitalization ⊗ Medical Care	○ Sharp Rees-Stealy ⊗ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Info session 4/29/19

Completed By (Print Name) _____ Signature _____ Date 4-29-19

4/29/19

San Diego State University

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ● Incident Only Report	2/19/2019 Supervisor's Date of Knowledge: none	8 a.m. ● a.m. ○ p.m. Date DWC-1 Given to Employee: 2/24/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40	☑	☐	☐	☐	☐	☐	☐	☐	8 ● a.m. ○ p.m.	4:30 ○ a.m. ● p.m.

INCIDENT INFORMATION

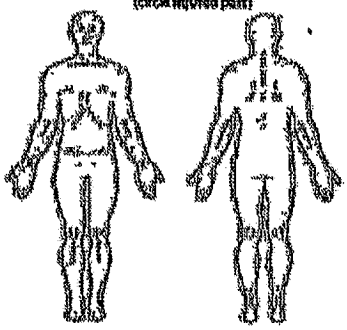
Injured Body Part: Head

Type of Injury: Headache

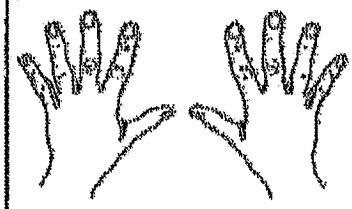
Action Causing Injury: Fumes in building

Contributing Object/Equipment:

(circle injured part)



BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)

Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Sealant used in roof repairs may have contributed to migraine headaches

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ● No ○	PSFA	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☑	Yes ○ No ●	Yes ● No ○
	Name & contact information of responsible party?	Were Campus Police notified?
		Yes ○ No ●

Did the employee miss any work related to the injury? No ● Yes ○ If yes, Date: Not sure Time From: none - per employee email attached To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ● Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	● Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed	☐ Employee Counseled Safety	☐ Personal Protective Equipment Ordered
☐ Training Scheduled	☒ Repairs Ordered	☒ Other: Displaced from PSFA building

Completed By (Print Name)

Signature

4/4/2019
Date

Rev. 4/23/14

4/4/19

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

SAN DIEGO STATE UNIVERSITY

Supervisor & HR Dock: 4/18/19

+ Fall Semester 2018

File as:	Date of Injury	Time of Injury	
○ Worker's Compensation Claim ☒ Incident Only Report	Feb 12 - 28, 2019	T/W/TH 10 AM - 7 PM	○ a.m. ○ p.m.
	Supervisor's Date of Knowledge: 3/27/19	Date DWC-1 Given to Employee: 2/24/19	

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40	☐	☐	☒	☒	☒	☒	☐	☐	10 ☒ a.m. ○ p.m.	7 ○ a.m. ☒ p.m.

INCIDENT INFORMATION

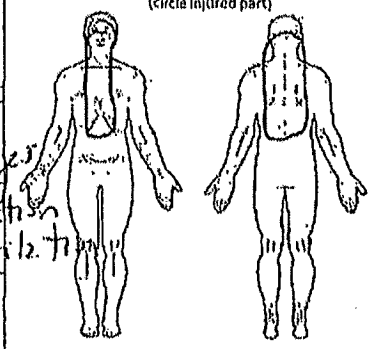
Injured Body Part: Lungs

Type of Injury: Coughing up mucus burning / itching eyes

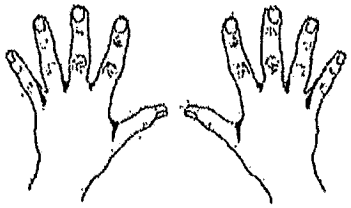
Action Causing Injury: Fumes from Construction black dust in Ventilation

Contributing Object/Equipment: Ventilation in PSFA

(circle injured part)

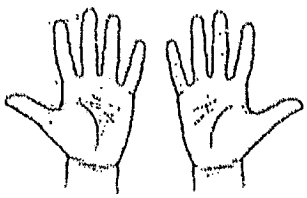


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

For several years, but particularly Fall 2018 / Spring 2019 black dust has come from the ventilation in my office. Feb 12 - 28, due to construction PSFA faculty staff students exposed to unbearable fumes causing various symptoms (coughing burning eyes

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA building	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ○ No ○ Construction Firm.	Yes ☒ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ☒

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
☒ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated

Completed By (Print Name)	Signature	Date
		4/17/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ☒ Incident Only Report	Feb 2019 - March 19 Supervisor's Date of Knowledge	○ a.m. ○ p.m. Date DWC-1 Given to Employee

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Red ID	Primary Phone
Department	Job Title (i.e. Custodian, Student Intern)	Email
Supervisor's Name	Supervisor's Work Phone	Supervisor's Email

Hours Worked Per Week:	Days Worked: M-F S M T W Th F S	Start time: ○ a.m. ○ p.m.	End Time: ○ a.m. ○ p.m.
40	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

INCIDENT INFORMATION

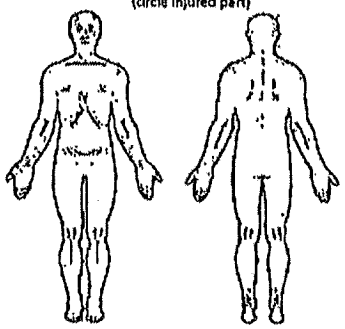
Injured Body Part: dizziness

Type of Injury: vomit

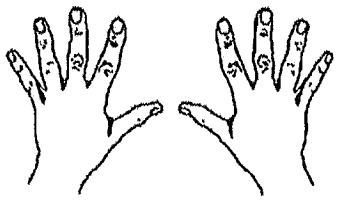
Action Causing Injury:

Contributing Object/Equipment:

(circle injured part)

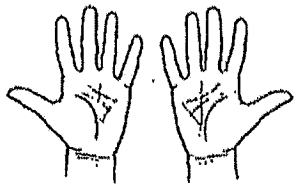


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

many days / dizziness, light headed, vomiting

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	
Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ☒	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
☒ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Info Session

Completed By (Print Name) Signature Date 4-30-19

4/30/19 Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim	deep coughs 2/1/19	Jan. 2019 ○ a.m. ○ p.m.
☒ Incident Only Report	Supervisor's Date of Knowledge: Feb. 2019 5/2/19	Date DWC-1 Given to Employee: 2/24/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Red ID	Primary Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40 +	☐	☐	☒	☒	☒	☒	☒	☐	☒ a.m. 10:00 ○ p.m.	○ a.m. varies ○ p.m.

INCIDENT INFORMATION

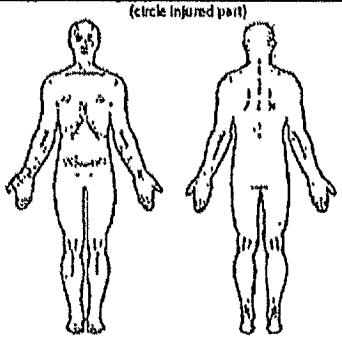
Injured Body Part: lungs

Type of Injury: coughing

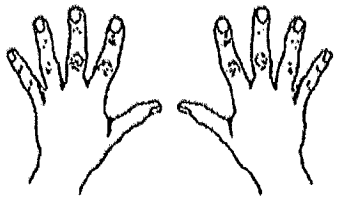
Action Causing Injury: fumes in PSFA

Contributing Object/Equipment: old building

(circle injured part)

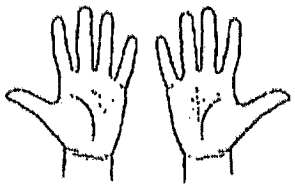


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

starting at beginning of spring semester, 2019, gassy fumes in PSFA caused coughing, runny nose, etc. Deep coughing still going on today (5/1/19).

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	PSFA	

Name & contact information of Witness: None ☐	Was another person responsible? Yes ○ No ☒	Were other employees injured? Yes ○ No ○
	Name & contact information of responsible party?	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ○ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
○ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	☒ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☒ Repairs Ordered ☒ Other: Relocated.

Completed By (Print Name) Signature Date: 5-1-19

Rev. 4/23/14

Rcv'd 5/2/19 5/2/19

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
☒ Worker's Compensation Claim ☐ Incident Only Report	Jan - Feb 2019 Supervisor's Date of Knowledge: 2/27/19	N/A ○ a.m. ○ p.m. Date DWC-1 Given to Employee: 2/24/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Interp)	Email

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M F S M T W Th F S	Start time:	End Time:
40	☐ ☒ ☒ ☐ ☒ ☐ ☒ ☐	○ a.m. ○ p.m.	○ a.m. ○ p.m.

INCIDENT INFORMATION

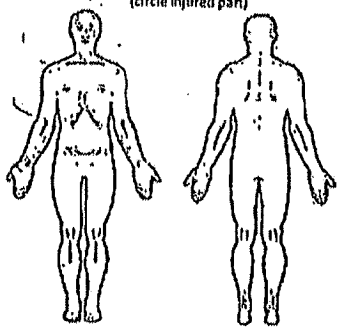
Injured Body Part

Type of Injury

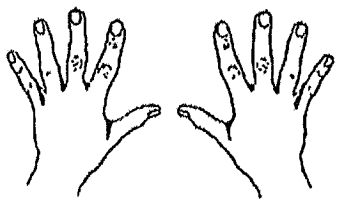
Action Causing Injury: Gas fumes

Contributing Object/Equipment

(circle injured part)

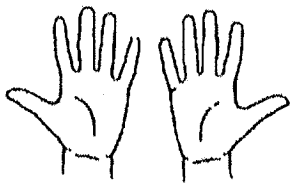


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Fumes causing headaches, dizziness, nausea.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ☒ No ○	ISF1	

Name & contact information of Witness:	Was another person responsible?	Were other employees injured?
None ☒	Yes ☒ No ○	Yes ○ No ☒
	Name & contact information of responsible party? ISF1	Were Campus Police notified? Yes ○ No ○

Did the employee miss any work related to the injury? No ☒ Yes ○ If yes, Date: Time From: To:

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
☒ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated

Completed By (Print Name)

Date: 4/8/19

Rev. 4/23/14

SAN DIEGO STATE UNIVERSITY

SUPERVISOR'S REPORT OF WORK-RELATED INJURY/ILLNESS

Complete this form in its entirety and submit within 24-hours of the injury

Please fax to 619-594-4013

File as:	Date of Injury	Time of Injury
○ Worker's Compensation Claim ◉ Incident Only Report	2/27/19	○ a.m. ○ p.m.
	Supervisor's Date of Knowledge: 1/30/19	Date DWC 1 Given to Employee: 2/26/19

EMPLOYEE INFORMATION

Employee's Name (Last, First)	Home Phone	Cell Phone	Work Phone

Department	Job Title (i.e. Custodian, Student Intern)	Email
HTM		

Supervisor's Name	Supervisor's Work Phone	Supervisor's Email	Supervisor's Fax

Hours Worked Per Week:	Days Worked: M-F	S	M	T	W	Th	F	S	Start time:	End Time:
40	☑	☐	☐	☐	☐	☐	☐	☐	◉ a.m. ○ p.m. 8:30	○ a.m. ◉ p.m. 4:00

INCIDENT INFORMATION

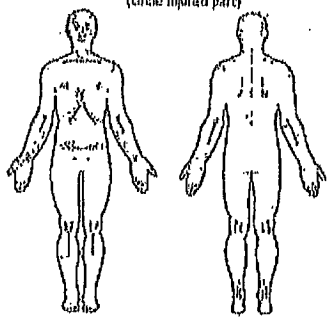
Injured Body Part: Head, eyes, throat

Type of Injury: Pain and irritation

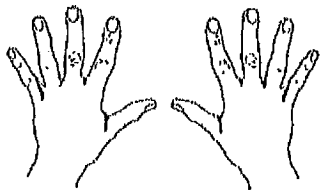
Action Causing Injury: Chemical fumes

Contributing Object/Equipment:

(circle injured part)

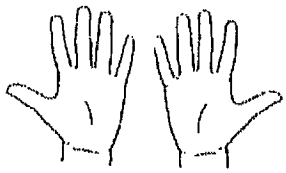


BACK OF HAND (circle injured part)



Left Right

FRONT OF HAND (circle injured part)



Left Right

Describe in detail how the accident occurred (i.e. Employee was opening a box and the box cutter slipped lacerating his left thumb.)

Strong fumes from the roof work being done in the building has been causing headaches and allergy type symptoms.

Did injury occur on campus?	Campus location where injury occurred	If not on campus, name & address of site
Yes ◉ No ○	PSFA	
Name & contact information of Witness: None ☐	**Was another person responsible?** Yes ○ No ◉	**Were other employees injured?** Yes ◉ No ○
	Name & contact information of responsible party?	**Were Campus Police notified?** Yes ○ No ◉

Did the employee miss any work related to the injury? No ○ Yes ◉ If yes, Date: We've been Time From: released To: early a few

MEDICAL INFORMATION

Medical Treatment Required	Medical Facility	If other, please complete the following:
◉ None ○ Emergency Room ○ First Aid ○ Hospitalization ○ Medical Care	○ Sharp Rees-Stealy ○ Other	Physician/Facility Name: Address: Phone:

CORRECTIVE ACTION

Supervisor's Investigation: What action will be taken to prevent recurrence? Check as many as appropriate.

☐ Safety Guidelines Developed ☐ Employee Counseled Safety ☐ Personal Protective Equipment Ordered

☐ Training Scheduled ☐ Repairs Ordered ☒ Other: Relocated 3/4/19

Completed By (Print Name) Signature Date: 2/27/19

3/19/19